Little Hoover Commission
California's Public Health System
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I. Public Health Government Infrastructure

The public health system in California is an interdependent responsibility shared by both the state and local city and county governments to control and track communicable disease, identify emerging infectious diseases, ensure environmental protection and food product safety, health education and prevention, particularly related to chronic disease and injury, and to perform epidemiology.

It has been woefully and historically underfunded.
California spends roughly $1.6 billion ($241 m state funding; $550 m federal funding) on public health programs which represents 6% of California's total health care budget and 1% of California's overall budget, -- a tiny fraction of a percent of total public and private health spending in the state.

Reasons for Underfunding: The public health system is invisible until there is a crisis, such as the recent Bioterrorism threats. Moreover, during times of recession public health funds tend to be transferred to other constituencies that are more politically visible. And the demand has grown while dollars have been cut.

Public health funds have been diverted to serve the uninsured.
Further, because our nation has failed to develop a comprehensive health coverage system for the uninsured and the numbers of uninsured continue to increase, public health dollars are diverted by counties to serve the uninsured medically indigent which leaves the public health infrastructure sorely neglected. In 1998 the counties served 1.3 million indigent patients at a total cost of over $1.3 billion.

Recommendations: To improve California's public health capacity.

1. Stable Funding Sources
   Much of public health is funded by declining funding sources: tobacco taxes, county general funds and realignment sales tax.
2. Comprehensive Coverage for the Uninsured to prevent public health diversion.
3. Program integration, coordination, and consolidation
   Most public health programs are not well coordinated between the state, counties and programs; Integration is essential to respond to statewide crises.
   4. Data. Consistent program definitions and expenditure reporting are needed to track programs.

II. **Real Time Communications:** Public Health Disease and Disaster Communications

There are new and exciting information technology opportunities today to link state and county public health leaders with community practicing physicians to coordinate disease and disaster reporting and response systems. California's health care system is overcapacity, operationally fragile and inelastic. Therefore, coordinated community and statewide communication systems will be vital to the success of the public health response, particularly in the event of a Bioterrorism attack.

For instance, the speed with which physicians and laboratories reach correct diagnoses and report finding to the public health authorities will directly affect the number of deaths. The ability to limit the spread of a contagious disease would depend on the critical decisions made in the hours immediately following an attack. A surge in patient demand will quickly overwhelm our health care systems so institutions must be coordinated to respond.

A strong communication system is vital to the public health infrastructure and it must accommodate a connection to the actual health care delivery system and the provider community.

Recommendations

1. State and Federal Funding to reinforce state and local communication system infrastructures, such as the current Reacts System.
2. Build communication systems between health authorities and community providers. CMA's MedePass allows physicians to communicate confidential medical information. Invezion is another internet based communication mechanism which should be explored.

III. **Trauma And Emergency Services**

California's emergency and trauma care system is an essential part of the public health infrastructure. It is the part of our health care system that remains the medical home for California's seven million uninsured. However, it is not just the safety net for the uninsured. Current nursing and physician shortages are creating a lack of available care for Medi-Cal and privately insured patients. Emergency departments have been transformed from providers of last resort to providers of first resort for many Californians. Medi-Cal, uninsured patients and county indigents accounted for 40% of all emergency room visits during 1998-1999. Over 80% of all Medi-Cal and uninsured visits to the emergency department were for conditions that could have been treated in a non-emergency care setting.

California's trauma and emergency services are in serious jeopardy today. ERs across the state are closing or reducing their services. In 1998-99 alone, ERs reported financial losses of over $315 million while serving 9.3 million patients. Physicians working in these same ERs experienced losses exceeding $100 million.

Because of these losses and the increasing demand, hospital diversions have increased dramatically. San Francisco General was forced to divert emergency patients 31% of the time last year. The entire system is in crisis.

Recommendations

1. Emergency Department, Emergency Back-up and Trauma services must be included as an essential public safety service with the police and firefighters.
2. These services must be funded and supported publicly as part of the public health infrastructure. Special funding sources must be identified and implemented.